



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DANIEL BARBARO MD  
1125 COLLEGE AVE  
FORT WORTH TX 76104

#### **Respondent Name**

PHOENIX INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number: 05

#### **MFDR Tracking Number**

M4-13-2964-01

#### **MFDR Date Received**

JULY 8, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The above claim was denied as 'Received Past Filing Deadline.' Please reprocess this claim for payment. The claim was originally filed on 07/19/2012, well within the filing deadline. Attached for your review is a copy of the electronic filing, and original HCFA claim form."

**Amount in Dispute:** \$2,609.15

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "...Although the Provider alleges an earlier submission date through the documentation of a billing roster alleging submission on 07/19/2012, the documentation presented supports only that the billing was printed, not that the billing was actually mailed or faxed to a valid contact for the Carrier. The presumption of Rule 102.4(h) applies, based on the later date, which is the Carrier's received date. As such, the documentation is insufficient to support timely filing, and the Carrier properly denied the medical bill."

**Response Submitted by:** Travelers, PO Box 163201, Austin, TX 78716

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10 through July 17, 2012	Antibiotic Infusion Therapy and Nurse Visit	\$2,609.15	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.

5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 29 – The time limit for filing has expired.
  - TXH3 – Per Texas Labor Code 480.027 [sic] bills must be sent to th [sic] carrier on a timely basis, within 95 days from dates of service.
  - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

### **Issues**

1. Did the requestor submit billing information or clinical documentation for the nurse visit listed on the Table of Disputed Services?
2. Is the timely filing deadline applicable to the medical bills for the services in dispute?

### **Findings**

1. According to the DWC-60 Table of Disputed Services, the requestor has listed a "Nurse Visit", with a disputed amount of \$135.00 for date of service July 17, 2012. The health care provider did submit a copy of a *Gateway EDI* submission showing a submission date of July 19, 2012 for date of service of July 17, 2012 for an amount of \$135.00, however, no HCFA-1500 nor clinical documentation were submitted showing an office visit was performed on this date of service with a charge of \$135.00. In accordance with 28 Texas Administrative Code §133.307(c)(2) states, in part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions); (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB..." as such, the requestor did not adhere to 28 Texas Administrative Code §133.307; therefore, reimbursement is not recommended.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." The requestor submitted an EDI Gateway claim status; however, the claim status does not confirm that the bill was submitted to the requestor. Therefore, review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	October 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**